Clinical Documentation Integrity

It's All About Effective Communication of Patient Care

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Clinical Documentation Improvement-Today’s Model

- **Patient Admission**
  - ED
  - H & P

- **Physician Documentation**
  - CDI Review
  - Query Process

- **Reimbursement**
  - CC/MCC
  - MS-DRG
Narrow Focused Scope of Work

- Clinical documentation improvement initiatives
  - Task based vs. Role based
  - Transactional
  - Reactional vs. Proactive
  - Short term gain vs. Sustainable improvement
- Repetitive with little change in physician documentation patterns
- Silo approach
- Non-synergistic approach
- Gross patient revenue vs. Net patient revenue
- Increased compliance and denials exposure

CORE CDI

THE REAL TRUTH
CDI-The Real Facts *

- Recent KLAS survey (KLAS Survey)
  - Revenue improved for 53% of respondents surveyed
  - Approximately 38 percent of respondents also reported improved workflow efficiency and 19 percent said reporting accuracy and metric tracking improved.

CDI-The Real Truth

- Fewer healthcare leaders and decisionmakers, however, are realizing financial gains in the form of increased acuity (18 percent), improved documentation quality (16 percent), fewer full-time equivalents (3 percent), and reduction in payer denials (1 percent).

- Potential to increase compliance exposure & denials cost to collect

- OIG Workplan Addition- Assessing Inpatient Hospital Billing for Medicare Beneficiaries
  - Concern with upcoding in hospital billing: the practice of mis- or over-coding to increase payment
    - OIG Work Plan
Revenue Cycle Considerations

- CERT Improper Payment Rate Report 2017
  - Majority of medical necessity denials are due to insufficient documentation
  - Insufficient documentation \neq More Documentation
  - Better is Better!

- Better is better
  - Complete, accurate, consistent, clear, concise and contextually correct communication of patient care
The Big Word Is Out...

• Communication of patient care vs. Documentation

• Holistic approach documentation integrity

• Communication
  • Patient care-presenting problem → Plan of care → Progression of care
  • Severity of Illness/Risk of Mortality
  • Medical necessity - Initial and continued stay
  • Diagnoses - Appropriate clinical specificity & relevant comorbidities

CORE CDI
Polling Question # 1

• Does your facility have Case Management staff in the ED?

1. Yes
2. No
3. Unsure

Synergistic Approach

• Physician
• CDI
• Case Management
• Utilization Review/Management
• Coding & Billing
Transforming Current CDI Processes

Moving in the Right Direction
- Getting from here to there
- Physician Advisor champion
- Creation of CDI vision that inspires all healthcare stakeholders

Creating a culture of change that facilitates meaningful improvement
- Operating in a vacuum vs. team environment
- All healthcare stakeholder mentality
- “All operations within a hospital are impacted by EMR documentation”

Emergency Department
CDIS
Coding & Billing
Case Management / UR
Physician Documentation
Communication of Patient Care
Case Study

- Emergency Department
  - Residents & ER attendings
  - Attendings-Hospitalists
  - Trauma Team
  - Specialists

- The real opportunities start here....

Make or Break

- Street or Street decisions
- Segway to hospitalization
- Congruence or disconnect
- Feast or Famine

Case Management in ED
- Role Identification & Definition

Scribes in the ED- Capitalizing Upon Opportunity
Polling Question #2

Does your CDI leadership receive feedback on medical necessity denials (concurrently and retrospectively) as well as clinical validation and DRG down-codes?

1. Yes
2. No
3. Not sure
What About Those Inpatient Medical Necessity Denials?

- Inpatient medical necessity denials & adversary LOC determinations
  - Accurate determination 3rd party payer
  - Misapplication of screening criteria
  - Insufficient and/or poor documentation

- ED Documentation
  - Does it accurately communicate patient care?
  - Describe, show, tell, depict, reflect, report and paint a clear pictured story?
  - Provisional/Differential diagnoses vs. Symptoms
  - Rabbit out of a hat
  - Root Cause Analysis-ED

Case Study

- **Chief Complaint** - Fever with shortness of breath

- **History of Present Illness**
- Mrs. Jones, a 75 year-old unfortunate female who presented to the Emergency Department this morning with chest pain and shortness of breath, she called 911 and was brought into the ED without incident. In the ED patient received breathing treatments, O2 and IV antibiotics. Feels is much better now.
Case Study

- **Physical Exam:**
- **VS:** Temperature 99°F, RR 18, HR 70, O2 sat 98%
- **Constitutional:** Alert and oriented X 3 in no acute distress talking in complete sentences
- **Lungs:** CTA with no rales, rhonchi or wheezing
- **Heart:** Regular rate and rhythm with no gallop or S3

- **Impression:**
  1. Acute respiratory failure with hypoxemia
  2. Fever with shortness of breath

Case Study—More Effective Communication

- **Chief Complaint:** Shortness of breath with fever last two days
- **History of Present Illness**
  - Mrs. Jones, a 75 year-old woman well known to me with repeated admissions for COPD exacerbation, 100 pack year history of smoking and continuing to smoke unwilling to stop presents to the ED with shortness of breath and subjective fever who by the way is on home O2 2 liters 24/7 for end stage COPD. Patient over the last two days developing increasing shortness of breath with productive cough, last night she had trouble catching her breath, turned up her O2 to 6 liters and still had trouble catching her breath, called 911 for transport to ED. Of note is household members sick with the crud and this might represent an acute exacerbation of COPD precipitated by acute bronchitis.
Case Study - More Effective Communication

Physical Exam:
- VS: Temperature 101°F, RR 28, HR 70, O2 sat 88% on 4 liters O2
- Constitutional: Alert and oriented X 3 in obvious respiratory distress speaking 2 word sentences, pursed lips with accessory muscle use
- Lungs: Rales with rhonchi and wheezing throughout
- Heart: Regular rate and rhythm with no gallop or S3

Impression:
1. Acute on chronic hypoxemic respiratory failure with hypoxemia
2. COPD exacerbation in a 100-year pack history of smoking
3. Fever- provisional diagnosis of early pneumonia with haziness seen on chest X-ray, WBC 25 with left shift, will need IV antbx, discussed case with attending who agrees to accept patient as inpatient

Polling Question #3

- Does your CDI program have an active engaged physician advisor who is paid a stipend or salary for his/her work?
  1. Yes
  2. No
  3. Unable to determine
The Construct

- Case Mgt
- UR-Initial & Continued
- ED
- Admission
- Progress Notes & D/C Summary
- Attending
- Ancillary
- CDI
Call To Action.....

- Take: Take Note and Evaluate current processes
- Capitalize: Capitalize upon opportunity to transform, reformulate, redirect, rebrand and refocus CDI mission and purpose
- Enhance & improve: Enhance & improve return on investment
- Create & monitor: Create & monitor valid & reliable KPIs
- Don’t Rest on: Don’t Rest on Laurels- CQI

Word to the Wise

The most dangerous phrase in the language is, "We've always done it this way."

-Grace Hopper
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